



Bob Holden
Governor

Division of Professional Registration
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Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753
573-751-3166 FAX
800-735-2966 TTY
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Tina Steinman
Executive Director

SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

The Board wishes to stress that you should provide complete details, dates, names, and addresses as required in your application. Answer all questions. If you do not, the processing of your application may be delayed indefinitely. Please type or print your application in black ink. The following information is provided to assist you in answering the questions.

SUPPLY A COPY OF YOUR TAX COMPLIANCE LETTER FROM THE DEPARTMENT OF REVENUE.

PLEASE SUBMIT A \$50 FEE PAYABLE TO THE MISSOURI BOARD OF HEALING ARTS ON A CASHIER'S CHECK OR MONEY ORDER.

Question #1 - Print your full name.

Question #2 - Please provide home address. B) Indicate home telephone number.

Question #3 - Indicate your current business address. B) Indicate business telephone number.

Question #4 - Indicate month, day, and year of birth. B) Indicate your sex. C) Indicate social security number.

Question #5 - List in chronological order the name and location of each institution attended, beginning with high school. Indicate the dates of attendance, graduation date and type of diploma or certificate awarded.

Question #6 - Indicate which profession you received your Certificate of Clinical Competence in. B) Indicate date certificate was issued. C) Indicate if certificate is valid or invalid.

Question #7 - List all licenses, certifications or registrations, whether active, inactive, temporary or institutional, in order of attainment.

Question #8-10 - If your answer is "yes", give full details on a separate notarized statement. This should include States/Providence's, dates and reasons.

Question #11 – If your answer is "yes", give full details on a separate notarized statement. Furnish a certified court copy (with the court seal affixed) of the complaint(s), answer(s) and disposition(s) of the case(s). If the case(s) is still pending, please so state. If your insurance company paid a claim without a formal case being filed, then include the dates, names of the patient(s) involved, insurance claim number, insurance carrier, and the facts and circumstances surrounding the claim. It will be necessary for you to contact the insurance carrier handling the claim and authorize them to submit directly to the Board all the information they have on file regarding the claim.

Question #12 – If your answer is “yes” give full details of the arrest, the dates, places and disposition of the case on a separate notarized statement. Furnish a Certified Court Copy (with the court seal affixed) of the original charge, the judgment, the sentence and/or the dismissal order, or other such documents which reflect the disposition of the matter.

This does not include any minor traffic parking violation fines. We suggest that if you have had an arrest (no matter minor), you answer the question “yes” on your application and furnish full details of the incident leading up to and including the arrest and disposition of the case.

Question #13 – If your answer is “yes” provide full details and dates, including the names and addresses of individuals who treated you and any hospitals/institutions where you have been treated on a separate notarized statement. Furnish a separate letter addressed to each therapist/institution authorizing them to release whatever information the Board may require from them. Our process requires writing to each individual/institution to verify information you have given us and obtain their records of your treatment.

Question #14-Applicants' Oath - You must sign this oath before a Notary Public. The Notary Public must complete his/her portion and sign, date and seal your signature. Also place a recent original photograph of yourself in the space provided. Copies of photographs or magazine clippings are not acceptable.

Activities Statement-Please complete the attached activities statement form and return with your application. It asks for your activities since the expiration of your license to the present.



STATE OF MISSOURI

BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 MISSOURI BOULEVARD – P.O. BOX 4
JEFFERSON CITY, MO 65102 (573) 751-0117

SPEECH-LANGUAGE PATHOLOGY AND/OR AUDIOLOGY LICENSURE

I HEREBY MAKE APPLICATION FOR LICENSURE AS A SPEECH-LANGUAGE PATHOLOGIST AND/OR AUDIOLOGIST IN THE STATE OF MISSOURI.

1. APPLICANT'S NAME (Last, First, Middle, Maiden)		
2. HOME ADDRESS (P.O. Box, Street, City, State, Zip)		HOME TELEPHONE NUMBER (S)
3. BUSINESS ADDRESS (P.O. Box, Street, City, State Zip)		BUSINESS TELEPHONE NUMBER (S)
4. DATE OF BIRTH	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	SOCIAL SECURITY NUMBER
5. EDUCATION List in chronological order the name and location of each institution attended, beginning with high school. Indicate the dates of attendance, graduation date and type of diploma or certificate awarded.		
NAME AND LOCATION OF INSTITUTION	YEAR FROM TO	DEGREE /AREA OF EMPHASIS
6. CERTIFICATE OF CLINICAL COMPETENCE ISSUED IN:		
SPEECH-LANGUAGE PATHOLOGY <input type="checkbox"/> DATE OF ISSUE _____		
CURRENTLY VALID? YES OR NO		
AUDIOLOGY <input type="checkbox"/> DATE OF ISSUE _____		
CURRENTLY VALID? YES OR NO		

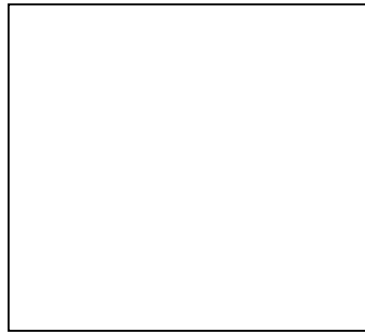
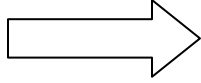
7. LIST ALL STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY AND/OR AUDIOLOGY.

STATE	LICENSE NUMBER	DATES HELD

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED YES, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.

- | | |
|---|--------|
| 8. Have you been denied any professional license / permit / certificate or professional privileges or denied the privilege of taking the examination before any professional board in the United States, Canada or other country? | YES NO |
| | |
| 9. Have you, or has any professional license / permit / certificate issued to you, been restricted or disciplined; such disciplinary action to include but not be limited to: revocation, suspension, probation, censure or reprimand, whether voluntarily agreed to or not, by any State within the United States, territory, federal agency, Canadian province, or other country? | YES NO |
| | |
| 10. Have you had any disciplinary action taken against you, or had your right to practice restricted, by any professional employer or any entity which you have trained, held staff membership or privileges, or acted as a consultant? | YES NO |
| | |
| 11. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? | YES NO |
| | |
| 12. Have you been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere (plea of no contest) to any criminal prosecution under the laws of any state of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence? | YES NO |
| | |
| 13. Have you had within the last five years, or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession including a (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; or (3) a physical disease or condition? | YES NO |

ALL APPLICANTS MUST PLACE AN
ORIGINAL RECENT PHOTOGRAPH
IN THE SPACE PROVIDED



14. APPLICANT'S OATH

State/Province of _____ County/Parish of _____.

I, _____, hereby certify under oath that I am the person named in this application for a license to practice Speech-Language Pathology and/or Audiology in the State of Missouri. That all statements I have made are true. That I am the original and lawful possessor of and person named in the various documents and credentials furnished to the board in connection with this application, and the photograph on this page is an identifiable photograph of myself.

I acknowledge and state that I have read the Statutes, Rules and Regulations pertaining to Speech-Language Pathology and/or Audiology and I have answered all questions in compliance with these Instructions. I understand that the fee I submitted is non-refundable.

I further state that by filing this application for a license to practice in the State of Missouri, hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of Speech-Language Pathology and/or Audiology, when in the opinion of the Missouri State Board of Healing Arts such an investigation is deemed necessary. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report unless determined otherwise by court order.

I authorize and request every person, hospital, clinic, community, government agency (local, state, federal or international), court, association, institution or other organization having control of any documents, records and other information pertaining to me to furnish to the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed or any other pertinent data and to permit the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice hereunder.

MUST BE SIGNED IN PRESENCE OF NOTARY **APPLICANT'S SIGNATURE** _____

On this _____ day of _____, _____ this applicant appeared before me and swore to the truthfulness of this application.

NOTARY PUBLIC EMBOSSER SEAL	STATE	COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS _____ DAY OF _____, 20____.	USE RUBBER-STAMP IN CLEAR AREA BELOW
	NOTARY PUBLIC SIGNATURE	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

SPEECH-LANGUAGE PATHOLOGIST/AUDIOLOGIST ACTIVITIES STATEMENT

INSTRUCTIONS: Complete this form providing a chronological listing of all professional and nonprofessional activities from expiration of your license to the present. All dates must be accounted for including all beginning and ending dates months and years. In **CHRONOLOGICAL ORDER**, list the position held, complete names, addresses and zip codes of employers. If unemployed or on vacation for more than one month, list your exact activities and locations.

NOTE: The failure to account for all time periods will delay the processing of your application.

DATES				EMPLOYMENT - ACTIVITIES
BEGINNING		ENDING		
MO	YEAR	MO	YEAR	

[illegible]